

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

28676

1. PLACE OF DEATH

County.....*St. Louis*..... Registration District No. *791*
 Township.....*University St*..... Primary Registration District No. *1003*
 City.....*St. Louis* (No. *2330*)..... Registered No. *8213*
 St.*St. Louis*..... Ward

2. FULL NAME

(a) Residence. No. *2330 University St.* St.*St. Louis*..... Ward *1003*
 (Usual place of abode)
 Length of residence in city or town where death occurred *7* yrs. *10* mos. *12* ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* | 4. COLOR OR RACE *White* | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widow*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Frank H. Springmeyer*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 23, 1874*

7. AGE YEARS MONTHS Days (UNLESS than 1 day, hrs. or min.)
83 | 1 | 23

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *At Home*
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Germany*

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Germany*

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Germany*

14.

INFORMANT *Henry Lindhorst*
 (Address) *2330 University St*

15.

FILED *SEP 10* 19 *1927* REGISTAR *New C. Starloff*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept. 15 1927*

17. I HEREBY CERTIFY, That I attended deceased from *Sept 12* 19 *27*, to *Sept 15* 19 *27*, that I last saw him alive on *Sept 12* 19 *27*, and that death occurred, on the date stated above, at *3:20 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Uremia *131*
1290 *89 D*
 (duration) yrs. mos. *2* ds.

CONTRIBUTORY (SECONDARY) *Ch. Nephritis, Hemiplegia due to Arteriosclerosis*
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS. *Labatory*

(Signed) *Anton Sundblad* M. D.

9/16, 1927 (Address) *2202 Laurent St*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

New Pickers *Sept. 17 1927*

20. UNDERTAKER

ADDRESS

Math. Hermann & Son *4032 West Florissant Ave.*

X. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECORDS IN THIS IS A PERMANENT RECORD

